NC Innovations Provider Referral Process

Per the 1915 (c) Home and Community Based Waiver it is Partners BHM's IDD Care Coordination responsibility to ensure individuals have Informed Choice of Providers. IDD Care Coordinators are responsible for assisting individuals/legally responsible persons in obtaining information about and selecting from among qualified providers of the waiver services in the service plan. The five components of this requirement are:

- The care coordinator, following the Partner BHM policy, assists the beneficiary/legally responsible person in choosing a qualified provider to implement each service in the ISP.
- The care coordinator meets with the beneficiary/legally responsible person and provides them with a provider listing of each qualified provider within the Partners BHM provider network and encourages the individual/legally responsible person to select providers that they would like to meet to obtain further information.
- The care coordinator provides any additional information that may be helpful in assisting them to choose a provider.
- Arranging provider interviews is facilitated by the care coordinator on behalf of the participant.
- Once the beneficiary has selected a provider, their choice of provider is documented in the service record.

Before a provider is selected:

When an individual enters the waiver, the initial meeting with a care coordinator will include educating the individual/legally responsible person on all NC Innovations waiver services available to meet his/her needs. In addition, the care coordinator provides the individual/legally responsible person the "Freedom of Choice" document and reviews the document with the individual/legally responsible person. This document is signed by the individual/LRP and is uploaded to the electronic record. Annually thereafter, the care coordinator reviews the individual/LRP their right to choose providers and the choice statement in the annual ISP is signed by the individual/LRP.

Care Coordinators are responsible for referring individuals to the providers within the closed network that are available to deliver identified services. Information and support should be made available to assist participants to freely choose among network providers. The Care Coordinator provides information to participants about their rights, protections, and responsibilities, including the right to change providers. The Care Coordinator assists the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP to the degree the participant/legally responsible person desires. The Care Coordinator meets with the participant/legally responsible person, provides them with a listing of each qualified provider within the provider network, and encourages them to select providers that they would like to meet to obtain further information.

Selecting a qualified provider:

The Care Coordinator provides any additional information that may be helpful in assisting them to choose a provider. The Care Coordinator, on behalf of the participant to the degree the participant/legally responsible person desires, facilitates arranging provider interviews. The following questions are sometimes helpful for

the participant/legally responsible person to ask a provider, to determine if their agency will be a good fit for the participant:

1. What is your philosophy regarding providing services to persons with developmental disabilities?

2. What are your staff's qualifications?

3. What backup system do you have in place when staff is absent, sick, on vacation?

4. Who do I inform if a staff does not show up to work with me/my family member?

5. How do you match staff to consumers?

6. How do you train staff? What basic trainings (i.e. CPR, first aid, medication administration, blood-borne pathogens, client rights, crisis behavioral documentation, etc.)? Additional and ongoing training?

7. Do you complete pre-employment drug screening and criminal checks? How often do you complete drug screenings once someone is employed?

8. Who monitors/supervises the staff and what are their credentials?

9. What happens if I am not satisfied with the services?

10. What happens if I decide to change the services that you are providing to a different mix of services?

11. Can you provide transportation to center-based and community-based activities?

12. May I participate in the hiring or selection of the staff member who will work with me or my family member?

13. Do you supply training materials?

14. If chosen, what is the projected date you can start services?

15. Do you have any written materials I can have about your agency and your services?

16. If selected as a provider, who will referral information need to be sent to?

17. How soon will you let us know if the individual is accepted into your services?

Once the individual/LRP has selected a provider(s), their choice if provider(s) is documented in the services record. *Note: this selection is not the final decision. This selection is the indication that this is the provider(s) the individual/LRP wants to pursue as the agency to provide services.

The Referral Packet:

Once the individual/LRP has made a provider selection (or selection of multiple providers to receive a referral packet for consideration) the care coordinator will obtain **Consent to Disclose Information forms** for each chosen provider. The care coordinator then documents the selection(s) in the service record via a **service note**. The care coordinator then completes **referral form(s)** and prepares **referral packet(s).**

Care Coordinators should obtain a copy of current short-term goals for continuity of care in a provider to provider transition.

The care coordinator will use the **Referral Packet Checklist** to gather items typically needed to send to a provider. Once the packet is received by the provider(s), they will review the information and determine their ability to accept the individual into their services.

It is imperative the packet is complete and sent within 3 business days of the choice selections, so the provider can ensure the following:

a. That they can accept the individual being referred
b. That staff will be trained and available to begin working with the individual on the identified start date
c. That they are familiar with the needs of the individual prior to serving them

NC Innovations Provider Service Referral Checklist

(Send a copy of this form as a cover sheet in the referral pack. Upload the original to the electronic record.)

Person Served Name:
Date of Birth:
Partners BHM ID#:
Medicaid ID#:
Care Coordinator:
Care Coordinator Phone #:

Provider Agency:
Provider Agency Admissions Contact Name/Number/Email/Address:
Name:
Number:
Email:
Address:

Service(s) being requested: Please include details such as the service name, how many units or hours per week, individual/group, etc.

Date requesting to begin services:

*REQUIRED DOCUMENTS

***Exception:** If an individual is new to the Innovations Waiver there is no Individual Support Plan attached, this is because the plan has not yet been approved. As soon as the plan is approved, a copy will be forwarded.

Document included in referral packet	Initial each document included	Check here if new to waiver, no ISP attached or item NA	Date and method referral packet sent (via encrypted email/fax/hand delivered/dropped off at provider office, etc.)
*Signed Referral Release of Information			
*Demographics Form			
*Most Recent SIS Summary Report			
*Most Recent Psychological Evaluation			
*Court Appointed Guardianship Doc (if appl)			
*Current Annual ISP & RSNA			
*All ISP updates since annual ISP			
*Individual Budget (Annual & Updates)			
*Copies of current authorizations			
*Positive Behavioral Support Plan if applicable			
*Current Short-Term Provider Goals			
Care Coordinator Signature and date:			